3 Transportation Guidelines

3.1 Introduction

This section covers Medicaid transportation services provided by the following provider specialties as deemed appropriate by the Department of Health and Welfare (DHW). It addresses the following:

- Medical transportation by individual, agency, and commercial transportation providers.
- Non-medical waiver transportation by individual, agency, and commercial transportation providers for participants on the Aged and Disabled (A&D) and Developmental Disabilities (DD) Waivers.
- Ambulance transportation by non-hospital based ambulance providers.

Note: Non-medical waiver transportation services are covered for Medicaid Enhanced Plan participants only.

It also addresses the following processes:

- Co-payments.
- Electronic and paper claim billing.
- Claims payment.
- Prior authorization (PA) procedures.
- Reconsideration requests and the appeals process.

3.2 Non-Emergent Transportation (NET)

Non-emergent transportation (NET) is a ride provided so that a Medicaid participant with no other transportation resources can be transported to receive Medicaid covered services.

Non-emergent transportation does not include emergency transportation, such as ambulance trips to the emergency room in life threatening situations.

Only the least expensive, most appropriate means of transportation will be authorized. Other necessary transportation related expenses may be authorized, such as meals (only exception - an overnight stay is required for travel), lodging, and medically necessary attendants for a Medicaid participant to receive covered medical care or treatment. The Department of Health and Welfare (DHW) will not pay for transportation, lodging, or meals when those services are available and provided at no cost by family, friends, or organizations such as Red Cross, Easter Seal Society, Cancer Society, fraternal and church organizations, Ronald McDonald Houses, and other private or social agencies.

3.2.1 Freedom of Choice

Participants are allowed freedom of choice to seek care from the Medicaid provider of their choice. However, transportation miles will not be authorized beyond the round trip distance to the closest and most appropriate provider.

See *IDAPA 16.03.09 Medicaid Basic Plan Benefits, Sections 870 Non-Emergency Transportation Services – Definition* through *Section 875 Non-Emergency Transportation Service Provider Reimbursement*, for rules governing transportation and Medicaid covered services for further information. A copy of the current transportation rules are available online at: **http://adm.idaho.gov/adminrules/rules/idapa16/0309.pdf**.

A paper copy can also be obtained by contacting the Administrative Procedures office for the State of Idaho during normal business hours at:

(208) 334-5552 in the Boise calling area

3.2.2 Participant Eligibility

Transportation providers are responsible for checking Medicaid eligibility for the Medicaid participants they are transporting and that the medical provider to whom the participant is transported is a participating Idaho Medicaid provider.

See *Section 1.3.4 Verifying Participant Eligibility*, *General Provider and Participant Information,* for more information.

3.2.3 Criminal History Check Requirements

The requirements for criminal history checks are listed in *IDAPA 16.03.09.009 Mandatory Criminal History and Background Check Requirements*. Commercial Non-Emergency Transportation Providers must receive a criminal history clearance. The criminal history check requirements applicable to commercial non-emergency transportation providers are found in Section 874 of these rules.

Non-Emergency transportation providers are required to have criminal history and background checks on their employees or contractors. All employees and contractors providing direct care services, or who have access to children or vulnerable adults, must register with DHWs Criminal History Unit and receive an employer identification number. This must be done before criminal history and background applications can be processed.

3.2.4 Important Billing Instructions

3.2.4.1 Dates of Service

Dates of service must be within the Sunday through Saturday calendar week within a single detail line on the claim. The calendar week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. on Saturday.

Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one claim detail line.

Example: A provider transports a participant every day from Friday the 10th to Tuesday the 14th. Enter the date of service Friday the 10th to Saturday the 11th on the first detail line. Enter the date of service Sunday the 12th to Tuesday the 14th on the second detail line.

Example: A provider transports a participant on the 10th, 14th, and 16th. Enter each date on a separate detail line.

3.2.4.2 Payment

Medicaid transportation providers will be reimbursed at the current rate established by DHW or the actual cost of the service, whichever is less.

3.2.5 Long-Term Care Nursing Facilities

Medicaid does not pay for local transportation to Medicaid covered services rendered to participants who reside in a nursing home or intermediate care facility (for developmentally disabled)/ mentally retarded (ICF/MR). These transportation services are the responsibility of the facility. Medicaid may pay for necessary transportation to Medicaid covered services for mileage over 50 miles round trip for residents in long-term care facilities. In this case, the facility must be enrolled as a Medicaid, agency transportation provider or they must use another Idaho Medicaid transportation provider. This transportation must be prior authorized.

3.2.6 Prior Authorization (PA)

Most transportation services require PA, which is authorized by DHW (or its designee) before the transportation occurs. Claims will not be paid unless the necessary PA was obtained prior to the transport. Refer to the appropriate procedure codes in *Sections 3.2.5 Long-Term Care Nursing Facilities*, *3.3.4 Diagnosis Code*, and *3.3.5 Individual Transportation Provider Billing Codes,* for details on services that do and do not require PA.

Non-medical waiver transportation services for developmental disabilities (DD), aged and disabled (A&D), and traumatic brain injury (TBI) require PA. In addition, the participant must have eligibility under the Medicaid Enhanced Plan. See *Section 3.5 Agency Transportation Providers*, for further information.

See *Section 3.6.5 Diagnosis Code*, for information and procedures regarding non-hospital based ambulance authorizations.

3.2.6.1 Obtaining Prior Authorization (PA)

Follow these procedures to request a PA for non-emergent transportation:

Make the request a minimum of 24 hours before any scheduled appointment time. Allow for weekends and state holidays.

Identify the Medicaid covered service.

Calculate one-way miles and cost per unit, prior to the request.

Use the DHW standardized Medicaid Non-Emergent Transportation Request form which is found in *Appendix D; Forms.*

After a request for PA has been submitted to DHWs authorizing agent or designee, DHW will initiate a, Notice of Decision for Medical Benefits to the participant and the transportation provider indicating which procedures are authorized or denied. The procedure codes authorized on the notice must match the procedure codes billed on the claim form. The PA number is required in box **23** of the CMS-1500 claim form or in the PA field of the electronic claim form.

Electronic claims: PA numbers can be entered at both the header and detail level.

Paper claims: Only one PA number can be billed per claim.

To submit a PA request mail to:

Division of Medicaid
Non-Emergent Transportation
PO Box 83720
Boise, ID 83720-0036

For DD and Mental Health (MH) related requests call:

(208) 287-1172 in the Boise calling area
(800) 296-0509 x 1172 (toll free)
Fax: 334-4979 or (800) 296-0513

All other non-emergent medical and out-of-state transportation requests call:

(208) 287-1173 in the Boise calling area
(800) 296-0509 x 1173 (toll free)
Fax: 334-4979 or (800) 296- 0513

Form Available:

- Transportation Request form and instructions are included in *Appendix D; Forms.*
- Providers may also contact MT for a paper or electronic copy of a blank request form.

3.2.7 Requests for Reconsideration

Providers may request a reconsideration of a PA decision made by DHW, by following these steps:

Step 1 Carefully examine the Notice of Decision for Medical Benefits to ensure that the requested services and procedure codes were actually denied. Occasionally a requested service/procedure code has been denied and the appropriate service/procedure code was actually approved on the next line in the notice.

Step 2 If you disagree with the DHW decision, you can complete a written Request for Reconsideration, which is found on the second page of the Notice of Decision. Include any additional extenuating circumstances and specific information that will assist the authorizing agent in the reconsideration review. Attach a copy (front and back) of the Notice of Decision for Medical Benefits.

Step 3 Submit the written request directly to MT within 28 calendar days of the mailing date, on the Notice of Decision for Medical Benefits.

Medicaid transportation will review the additional information and return a second Notice of Decision for Medical Benefits to the requestor within five working days of receipt of the provider's Request for Reconsideration.

If the reconsidered decision is still contested, the provider may then submit a written request for a contested case hearing. Medicaid consumers may request a fair hearing. The Notice of Decision for Medical Benefits includes instructions for providers and participants to file a contested case or fair hearing.

Step 4 Maintain copies (front and back) of all documents in your records for a period of five years.

3.2.8 Request for Hearing

Step 1 Prepare a written request for a hearing which must include:

- A copy of the Notice of Decision for Medical Benefits on which the provider requested the reconsideration.
- A copy of the Request for Reconsideration letter from MT, which upheld the denial.
- Copies of any additional supporting documentation which should be considered at a hearing.

Step 2 Mail or fax the information to:

Idaho Department of Health and Welfare
Hearings, Medicaid Transportation
PO Box 83720
Boise, ID 83720-0036
Fax: (208) 334-6558

Medicaid Transportation (MT) will submit all documentation to the hearing officer who will schedule a hearing.

Contact MT with any questions about the Notice of Decision for Medical Benefits, the reconsideration decision, or the appeal process.

3.3 Individual Medical Transportation Providers

3.3.1 Definition from Provider Agreement

Individual Transportation Provider (1.6): Shall mean any individual who does not meet the definition of a commercial (or agency) transportation provider and provides transportation services to a Medicaid participant in a personal vehicle.

Individual providers may be the Medicaid participant, a family member, guardian, friend, or other volunteer driver.

3.3.2 Transportation Related Services

An attendant is an additional individual (other than a driver) who accompanies the participant to medical services if deemed necessary due to the participant's age or other mental/physical conditions. Attendant salary is never paid to a participant's spouse or the parent of a minor child.

In special circumstances, Medicaid transportation (MT) may authorize meals and lodging when an overnight stay is required. Only the most appropriate, least expensive lodging will be authorized. The rules governing non-emergent transportation are found at: **http://adm.idaho.gov/adminrules/rules/idapa16/0309.pdf**, *IDAPA 16.03.09 Sections 870 Non-Emergency Transportation Services – Definition* through *875 Non-Emergency Transportation Service Provider Reimbursement*. Meals and lodging are reimbursed at the rate established by Idaho Medicaid, or the actual cost, whichever is less, and only when an overnight stay is authorized. The meals and lodging for one attendant may be authorized if the participant is a child or an adult whose physical or mental condition requires an attendant.

If meal preparation facilities such as a microwave oven are available in the authorized lodging facility, meals will not be authorized. Every effort is made to arrange for necessary lodging with cooking or microwave accommodations. Lodging and meals will not be authorized if the participant and/or attendant stay in a private home that is not a lodging facility available to the general public. Medicaid transportation will authorize payment either directly to the lodging facility or to the participant's individual transportation provider.

3.3.3 Place-of-Service (POS) Code

Enter the POS code **99** in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.3.4 Diagnosis Code

Enter the ICD-9-CM diagnosis code **7999** - Other Unknown, in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.3.5 Individual Transportation Provider Billing Codes

All claims must use the following 5-digit codes when billing for non-emergency transportation, meals, and lodging services. Descriptions of the code and PA requirements are also indicated.

Service	Procedure Code	PA Required	Description
Airline travel	**A0140**	Yes	Non-emergency transportation and air travel (private or commercial), intra or interstate. 1 Unit = 1 Airline ticket.
Attendant salary	**T2001**	Yes	Non-emergency transportation, patient attendant/escort (salary). Spouse or parent of a minor child cannot be paid as attendant. 1 Unit = 15 Minutes.
Bus pass, city bus with a fixed route within the city limits	**T2004**	Yes	Non-emergency transport, commercial carrier, multi-pass (bus pass). Usually valid for 1 calendar month (or more). 1 Unit = 1 City bus pass.

Service	Procedure Code	PA Required	Description
Car rental	**T2003**	Yes	Non-emergency transportation, encounter/trip (car rental). 1 Unit = 1 Rental car.
Lodging for participant	**A0180**	Yes	Non-emergency transportation, ancillary, lodging – participant. 1 Unit = 1 Days lodging.
Lodging for attendant	**A0200**	Yes	Non-emergency transportation, ancillary, lodging – attendant/escort. 1 Unit = 1 Days lodging.
Meals for participant	**A0190**	Yes	Non-emergency transportation, ancillary, meals – recipient. When travel requires an overnight stay. 1 Unit = 1 Days total meal charges.
Meals for attendant	**A0210**	Yes	Non-emergency transportation, ancillary, meals – attendant/escort. When travel requires an overnight stay. 1 Unit = 1 Days total meal charges.
Mileage: 21 miles or more	**S0215** **TF** Modifier Required	Yes	Non-emergency transportation, mileage, per mile. Individual, 400 miles and over. Agency, 21 miles and over. 1 Unit = 1 Mile. Code must be reported with modifier **TF**
Mileage: 0 – 20 miles	**S0215**	No	Non-emergency transportation, mileage, per mile. Individual, under 400 miles. Agency, under 20 miles. 1 Unit = 1 Mile.
Parking fees and tolls	**A0170**	No	Transportation, ancillary, parking fees, tolls, other. Attach receipt to claim form. 1 Unit = 1 Days total fees.
Taxi, intra city	**A0100**	Yes	Non-emergency transportation, taxi (city taxi). 1 Unit = 1 One-way trip.

3.4 Commercial Transportation Providers

3.4.1 Definition from Provider Agreement

Commercial Transportation Provider (1.3): Shall mean an entity in the business of transportation that is organized to provide, that publicly holds itself out to provide, and that actually provides personal transportation services to the general public. By holding itself out to the general public, the provider vigorously and diligently solicits riders from the general populace. By actually providing services to the general public, the provider ridership includes substantial numbers of persons whose travel is funded by a source other than Medicaid.

Commercial providers may include:

- Taxis.
- Intra/inter city buses or vans.
- Intrastate/interstate buses (such as Greyhound) or vans.
- Airlines (travel agencies).
- Car rental agencies.
- Lodging facilities.

Reimbursement is at the rate established by Idaho Medicaid, or the actual cost, whichever is less.

Note: All employees and contractors providing direct care services, or who have access to children or vulnerable adults, must register with DHWs Criminal History Unit.

All transportation services provided by commercial carriers require PA by MT.

3.4.2 Place-of-Service Code

Enter the Place-of-Service code **99** in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.4.3 Diagnosis Code

Enter the ICD-9-CM diagnosis code **7999 -** Other Unknown, in field **21** on the CMS-1500 claim form or the appropriate field of the electronic claim form.

3.4.4 Commercial Transportation Provider Billing Codes

Idaho Medicaid uses *HCPCS* procedure codes. All claims must include the following 5-digit codes when billing for non-emergency transportation and lodging services. Providers and participants will receive a Notice of Decision for Medical Benefits, which will identify the procedure codes that have been approved and are to be used for billing.

DEFINITIONS:
Bus: A commercial vehicle with a capacity of 16 or more passengers (including the driver) and requires the driver to have a certified drivers license (CDL) and any necessary endorsements.

Van: A commercial vehicle with a capacity up to 15 passengers (including the driver).

Service	Code	PA	Description
Airline travel	**A0140**	Yes	Non-emergency transportation and air travel (private or commercial), intra or interstate. Attach receipt to claim form. 1 Unit = 1 Airline ticket.
Attendant salary	**T2001**	Yes	Non-emergency transportation, attendant/escort (salary). Spouse or parent of a minor child cannot be paid as attendants. 1 Unit = 15 Minutes.

Service	Code	PA	Description
Bus or van travel	**A0110**	Yes	Non-emergency transportation and bus, intra or interstate carrier. Also used for demand response, door-to-door, or curb-to-curb transportation provided by a commercial van or bus provider. 1 Unit = 1 Loaded vehicle mile.
Bus pass, city bus fixed route within the city limits	**T2004**	Yes	Non-emergency transport, commercial carrier, multi-pass (bus pass). Usually valid for 1 calendar month (or more). 1 Unit = 1 City bus pass.
Car rental	**T2003**	Yes	Non-emergency transportation, encounter/trip (car rental). Attach receipt to claim form. 1 Unit = 1 Rental car.
Lodging participant	**A0180**	Yes	Non-emergency transportation, ancillary, lodging - recipient. Attach receipt to the claim form. 1 Unit = 1 Days lodging.
Lodging attendant	**A0200**	Yes	Non-emergency transportation, ancillary, lodging – attendant/escort. Attach receipt to the claim form. 1 Unit = 1 Days lodging.
Meals for participant	**A0190**	Yes	Non-emergency transportation, ancillary, meals – recipient. When travel requires an overnight stay. 1 Unit = 1 Days total meal charges.
Meals for attendant	**A0210**	Yes	Non-emergency transportation, ancillary, meals – attendant/escort. When travel requires an overnight stay. 1 Unit = 1 Days total meal charges.
Taxi intra-city	**A0100**	Yes	Non-emergency transportation, taxi (city taxi). Attach receipt to claim form. 1 Unit = 1 One-way trip.
Non-emergency transportation, per mile (A&D Waiver non-medical transportation)	**A0080** **U2** and **SE** Modifiers Required	Yes	Aged and Disabled (A&D) Waiver non-medical transportation, per mile, as authorized by Regional Medicaid Services. 1 Unit = 1 Mile. Maximum allowable of 1,800 miles per year.
Non-emergency transportation, per mile	**A0080** **U8** and **SE** Modifiers Required	Yes	Developmental Disabilities (DD) Waiver non-medical transportation, per mile, as authorized by Regional Medicaid Services. 1 Unit = 1 Mile. Maximum allowable of 1,800 miles per year.

3.5 Agency Transportation Providers

3.5.1 Definition from Provider Agreement

Agency Transportation Provider (1.1): Shall mean any of the following:

- An entity whose employees or agents provide transportation services in addition to one or more other services to the same Medicaid participant.
- An entity whose employees or agents transport Medicaid participants to or from another Medicaid service in which the entity has ownership or control.
- An entity whose employees or agents transport Medicaid participants pursuant to an arrangement that is not an arm's-length transaction.

All transportation services for a participant that are over 20 total loaded miles in one calendar day require PA by MT. See *Section 3.5.5 Agency Provider Procedure Codes*, for details on those services that do and do not require PA.

3.5.2 Transportation Related Expenses

Agency transportation providers do not supply meals or lodging and, therefore, cannot bill for these services.

3.5.3 Place-of-Service (POS) Code

Enter the POS code **99** in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.5.4 Diagnosis Code

Enter the ICD-9-CM code **7999** - Other Unknown, for the diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic transaction.

3.5.5 Agency Provider Procedure Codes

Service	Procedure Code	PA Required	Description (Notes)
Attendant salary	**T2001**	Yes	Non-emergency transportation, patient attendant/escort (salary). Spouse or parent of a minor child cannot be paid as attendants. 1 Unit = 15 Minutes.
Bus pass, city bus with a fixed route within the city limits	**T2004**	Yes	Non-emergency transport, commercial carrier, multi-pass (bus pass). Usually valid for one calendar month (or more). 1 Unit = 1 City bus pass.
Mileage 21 miles or more	**S0215** **TF** Modifier Required	Yes	Non-emergency transportation, mileage, per mile. Agency, 21 miles and over. 1 Unit = 1 Mile. *Code must be reported with modifier **TF**.
Mileage 0 – 20 miles	**S0215**	No	Non-emergency transportation, mileage, per mile. Agency, under 20 miles. 1 Unit = 1 Mile.

3.6 Non-Medical Waiver Transportation Services – Aged and Disabled (A&D) Waiver, Developmental Disabilities (DD)/Idaho State School and Hospital (ISSH) Waiver

3.6.1 Non-Medical Waiver Transportation Services

Medicaid participants who qualify for waiver services may receive non-medical transportation services to gain access to community services, and other waiver or waiver related services required by the plan of care. This service is in addition to medical transportation services and does not replace them. Waiver transportation is limited to 1,800 miles per year.

Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized.

Waiver transportation may be provided by a commercial, agency, or individual transportation provider.

Additional information about provider reimbursement for all non-emergency transportation services, including non-medical transportation under waiver programs, is described in *IDAPA 16.03.09.875 Medicaid Basic Plan Benefits, Non-Emergency Transportation Service Provider Reimbursement.*

Specific requirements, qualifications, and limitations for non-medical, waiver transportation are described in, *IDAPA 16.03.10 Medicaid Enhanced Plan Benefits*. Non-medical, waiver transportation is described in *Subsection 326.04 Aged and Disabled Waiver Services* and *Subsection 703.05 DD/ISSH Waiver Participants*.

Note: Non-Medical Transportation waiver services are covered for Medicaid Enhanced Plan participants only.

3.6.2 Payment

Payment for non-medical waiver transportation is reimbursed at the per-mile rate established by Idaho Medicaid and is limited to 1,800 miles per calendar year. The vehicle's owner is responsible for all necessary insurance. A commercial agency or individual transportation provider may provide waiver transportation services.

Providers and participants receive a PA notice that identifies the procedure codes that have been approved and are to be used for billing. The PA number must appear on the claim or the claim will be denied.

3.6.3 Prior Authorization (PA)

A PA will identify the procedure codes that have been approved and are to be used for billing. Commercial transportation providers may request PA at the commercial rate for non-medical, waiver transportation. Agency and individual transportation providers will continue to be reimbursed at the agency or individual rate, respectively. Prior Authorizations for wavier transportation services are issued by the regional DHW offices. Regional Office phone numbers for PAs are listed below:

Area	City	A&D Waiver	DD/ISSH Waiver
Region I	Coeur d'Alene	**(208) 769-1567**	**(208) 769-1588**
Region II	Lewiston	**(208) 799-4430**	**(208) 799-3460**
Region III	Caldwell	**(208) 455-7150**	**(208) 459-0092**
Region IV	Boise	**(208) 334-0940**	**(208) 334-0900**
Region V	Twin Falls	**(800) 736-3024**	**(208) 736-2182**
Region VI	Pocatello	**(208) 239-6260**	**(208) 234-7900**
Region VII	Idaho Falls	**(208) 528-5750**	**(208) 525-7223**

3.6.4 Procedure Codes

Providers must use the PA number and the appropriate procedure code and modifiers to be reimbursed for services:

Service	Code	Modifiers for Agency & Individual Providers	Modifiers for Commercial Providers	PA Required	Description
A&D Non-Medical Transportation Non-emergency transportation, per mile, vehicle provided by volunteer (individual or organization), with no vested interest.	**A0080**	**U2**	**U2** and **SE** Modifiers Required	Yes	A&D non-medical transportation, per mile as authorized by the RMS. 1 Unit = 1 Mile. The maximum allowable units per year are 1800. **Requires modifier **U2** to report services for the A&D Waiver.
DD Non-Medical Transportation Non-emergency transportation, per mile, vehicle provided by volunteer (individual or organization) with no vested interest.	**A0080**	**U8**	**U8** and **SE** Modifiers Required	Yes	DD non-medical transportation, per mile as authorized by the RMS. 1 Unit = 1 Mile. The maximum allowable units per year are 1800. ** Requires modifier **U8** to report services for the DD Waiver.

3.6.5 Diagnosis Code

Enter the ICD-9CM diagnosis code **7999** - Other Unknown, for the primary diagnosis in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.6.6 Place-of-Service (POS) Code

Non-medical transportation can only be provided in the following POS:

99 Other (Community)

Enter this information in field **24B** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.7 Ambulance (Non-Hospital Based) Transportation Service Policy

3.7.1 Overview

Ambulance services are payable by Medicaid only if used in the event of a medical emergency or after PA has been obtained from Medicaid Ambulance Review. Medicaid Ambulance Review manages ambulance transportation services including PA of non-emergency ambulance transportation and medical review of emergency ambulance claims. Ambulance service must be medically necessary, as determined by Medicaid Ambulance Review, in order to be paid by Medicaid.

Policy and billing information for hospital-based ambulance services can be found in the *Hospital Guidelines, Section 3.9 Ambulance Service Policy*. The Hospital Guidelines are available online at: **http://www.healthandwelfare.idaho.gov/site/3438/default.aspx**.

3.7.2 Definition of Emergency Services

Medical necessity is established when the participant's condition is of such severity that use of any other mode of transport would endanger the participant's life or health. An emergency exists when the severity of the medical situation is such that the usual PA procedures are not possible because the participant requires immediate medical attention. See *Section 3.7.7.3 Base Rate for Ambulances*, for a description of ambulance levels of care.

3.7.3 Definition of Non-Emergency Service

Medicaid defines a non-emergency ambulance service as scheduled ambulance transport, which is medically necessary due to the medical condition of the participant, when any other form of transportation will place the participant's life or health in serious jeopardy. This includes inter-facility transfers, nursing home to hospital transfers, and transfers to the participant's home from the hospital. All scheduled, non-emergency ambulance transports must be approved prior to the transport.

3.7.4 Co-Payment for Non-Emergency Use of Ambulance Transportation Services

Idaho Medicaid implemented co-payment provisions of House Bill #663 passed by the 2006 Idaho legislature. Beginning with dates of service on or after February 1, 2007, ambulance providers may bill Medicaid participants a $3.00 (three dollar) co-payment for inappropriate ambulance service utilization when the following conditions are met:

The Department of Health and Welfare determines that the Medicaid participant's medical condition did not require emergency ambulance transportation.

The Department of Health and Welfare determines that the Medicaid participant is not exempt from making co-payments according to Federal statute.

The Department of Health and Welfare will notify both the ambulance provider and the Medicaid participant on the Notice of Decision letter when a participant may be billed for a co-payment.

Note: Collection of the co-payment is at the discretion of the provider and is not required by Idaho Medicaid.

3.7.5 Licensing Requirements

Medicaid ambulance service providers must hold a current license issued by the Emergency Medical Services (EMS) Bureau and must comply with the rules governing EMS services. Ambulance services based outside the State of Idaho must hold a current license issued by that state's EMS licensing authority.

Emergency Medical Services (EMS) Bureau
(208) 334-4000 in the Boise calling area
Fax: (208) 334-4015

3.7.6 Billing Information

Non-hospital based ambulance providers may bill electronically or on the CMS-1500 claim form. Forms are available from local form suppliers.

Required attachments include third party payer Explanation of Benefits (EOB) for payments or denials.

3.7.6.1 Customary Fees

Ambulance service charges to Medicaid cannot exceed the provider's charges to the public for the same service (usual and customary fee). Reimbursement for non-hospital based ambulance service is at the rate established by Idaho Medicaid.

Transportation of nursing home or ICF/MR residents is the responsibility of the facility unless the medical condition of the participant requires ambulance transport. All non-emergency ambulance transports must be prior authorized by Medicaid Ambulance Review.

3.7.6.2 Payment in Full

The claimants certification, (reverse side of the CMS claim form) signed on each claim submitted for payment, indicates the Medicaid payment for the charges on that claim will be accepted as payment in full for the services rendered. The participant is not responsible for the unpaid balance remaining on covered services, and should not be billed.

3.7.6.3 Medicare Participants

If a participant has Medicare coverage, the provider must first bill Medicare for services rendered. See *Section 2.4 Third Party Recovery (TPR)*, for billing instructions.

3.7.6.4 Submitting Claims to EDS

Providers must document the PA number on the claim form and submit the claim to EDS for payment. When billing electronically, PA numbers can be entered at either the header or the detail level. When billing on paper, the provider can only use one PA number, at the header level, for each claim. The provider's claim must match the authorized services on the Notice of Decision for Medical Benefits or the claim will be denied. Contact Medicaid Ambulance Review with questions, pertaining to the review of ambulance claims.

3.7.7 Covered Services

3.7.7.1 Air Ambulance

Medicaid covers air ambulance services when one of the following occurs:

- The point of pickup is inaccessible by a land vehicle.
- Great distances or other obstacles are involved in getting the participant to the nearest appropriate facility and urgent medical care is needed.
- The participant's condition and other circumstances necessitate the use of air ambulance.
- If ground ambulance services would suffice and be less costly, payment is based on the amount that would be paid for a ground ambulance.

Air ambulance must be approved by Medicaid Ambulance Review in advance, except in emergency situations. Non-hospital based air ambulance services must be billed on the CMS-1500 claim form, using HCPCS codes. Only air ambulances that are owned or leased, and operated by a hospital are designated by Idaho Medicaid as hospital based. The services must be billed on a UB-04 claim form using revenue codes from *Section 3 Hospital Guidelines.*

3.7.7.2 Ground Ambulance

Non hospital-based, ground ambulance services must be billed on a CMS- 1500 claim form using HCPCS procedure codes. Only ground ambulances that are owned or leased, and operated by a hospital are

designated by Idaho Medicaid as hospital-based. Those services must be billed on a UB-04 claim form using revenue codes found in *Section 3 Hospital Guidelines.*

3.7.7.3 Base Rate for Ambulances

Levels of Service: Providers may report one of the following levels of service for transporting Medicaid participants. Providers may also request payment for treat and release or respond and evaluate if the patient is not transported. The three levels of service are:

- Basic Life Support (BLS) (emergency and non-emergency).
- Advanced Life Support (ALS) I (emergency and non-emergency).
- Ground specialty (above the level of Paramedic).
- ALS II (emergency and non-emergency).

When reviewing and authorizing a particular level of service Medicaid Ambulance Review must consider if:

- The requested level of service is equal to or below the level of EMS certification of the personnel providing care in the patient compartment of the vehicle.
- The certification level of the provider is documented on the patient care record.
- The type of care provided corresponds with the level of service requested.

Each level of service corresponds with the Idaho Administrative Code acts and duties allowed for the pre-hospital care providers, as per *IDAPA 16.02.03.325 Pre-Hospital Advanced Life Support (ALS) Standards*, available online at: **http://adm.idaho.gov/adminrules/rules/idapa16/0203.pdf**. The following may be used as a guideline in determining the level of service.

Separate fees are not allowed for components of BLS or ALS care, such as starting IVs and administering oxygen. This includes all non-disposable equipment used in the treatment such as backboards, scoop stretchers, and cervical collars. Disposable (consumable) equipment and medications are included in the base rate payment for ground ambulance services and may not be billed separately.

Basic Life Support (BLS): BLS includes all acts and duties that may be performed by a certified Emergency Medical Technician - Basic (EMT-B). The care may be provided by personnel with a higher level of certification (e.g., advanced EMT-A, EMT-paramedic, registered nurse), but if the care provided falls within the scope of practice for the EMT-B, the level of reimbursement is BLS. Common examples include patient assessment, bleeding control, spinal immobilization, the use of oxygen and splints. For a complete list of the skills and duties allowed for an EMT-B, refer to the Board of Medicine Rules for EMS personnel. For a complete list of the skills and duties allowed, refer to *IDAPA 16.02.03 Emergency Medical Services* at: **http://adm.idaho.gov/adminrules/rules/idapa16/0203.pdf**.

Advanced Life Support (ALS) Level I (emergency and non-emergency): ALS Level I emergency and non-emergency includes the transportation by ambulance and the provision of at least one medically necessary ALS intervention or treatment. An ALS intervention is a procedure that is beyond the scope of practice of an EMT-B. Common examples include peripheral venous puncture, electrocardiogram (EKG) rhythm interpretation, and administration of various medications used in medical, respiratory, or behavioral emergencies. For a complete list of the skills and duties allowed, refer to *IDAPA 16.02.03 Emergency Medical Services* at: **http://adm.idaho.gov/adminrules/rules/idapa16/0203.pdf**.

Advanced Life Support (ALS) Level II: ALS Level II includes the transportation by ambulance and the medically necessary administration of at least three separate administrations of one or more medications by intravenous push/bolus or continuous infusion or one of the following medically necessary treatments:

- Manual defibrillation/cardioversion.
- Endotracheal intubation.
- Central venous line.

- Cardiac pacing.
- Chest decompression.
- Surgical airway.
- Intraosseous line.

3.7.7.4 Waiting Time and Extra Attendants

Waiting time and extra attendants are not paid unless medically necessary and authorized by Medicaid Ambulance Review. Waiting time must be physician ordered.

3.7.7.5 Multiple Runs in One Day

When the ambulance transports a participant, returns to the base station, and transports the participant a second time on the same date, two base rate payments and loaded mileage are allowed. Use modifier 76 on the second procedure code to prevent denials for duplicate claims.

When the ambulance transports a participant, the participant is transferred to another facility, and the ambulance does not return to the base station, one base rate, waiting time, and loaded mileage are allowed.

3.7.7.6 Round Trip

Medicaid allows round-trip charges when a hospitalized participant is transported to another hospital to obtain specialized services not available at the original hospital, and the referral hospital is the nearest one that offers special services.

Medicaid places restrictions on round-trip charges, depending on whether the ambulance returns to the base station between trips. When the ambulance does not return to base station, bill for one base rate, round-trip loaded miles, and waiting time (limited to one and one-half hours). When the ambulance does not wait but returns to the base station between trips, bill for two base rates and loaded round-trip mileage.

3.7.7.7 Physician in Attendance

When a physician is in attendance, the documentation should justify the necessity and specialty type of the physician. The physician is responsible for the billing of their services.

3.7.7.8 Nursing Home Residents

Ambulance services are covered only in an emergency situation or when prior authorized by Medicaid Ambulance Review. Payment for any non-covered, non-emergency service is the responsibility of the facility and ambulance providers may not bill Medicaid.

3.7.7.9 Trips to Physician's Office

Ambulance service from a participant's home to a physician's office is not covered unless prior authorized by Medicaid Ambulance Review.

3.7.7.10 Treat and Release

A treat and release payment may be authorized if the participant is treated at the scene and not transported. Disposable supplies are included in the treat and release payment. Treat and release may be requested at the BLS or ALS level, depending on the treatment provided. See *Section 3.7.7.3 Base Rates for Ambulances*, for details on determining the appropriate level of service.

Medicaid Ambulance Review may downgrade a claim to a treat and release payment if the participant was transported but the transport is determined to not be medically necessary. No mileage will be paid.

3.7.7.11 Respond and Evaluate

A respond and evaluate payment may be authorized if the ambulance responds to the scene and evaluates the participant, but treatment or transport is not necessary.

Medicaid Ambulance Review may downgrade a claim to a respond and evaluate payment if the participant was transported, but the transport is determined to not be medically necessary. No mileage, supplies, nor other services will be paid in addition to payment for respond and evaluate.

Contact Medicaid Ambulance Review at:

(208) 287-1157 in the Boise calling area
(800) 362-7648 (toll free)
Fax: (208) 334-5242 or (800) 359-2236

3.7.7.12 Deceased Participants

Ambulance service for deceased participants is covered when documented in the run sheet as follows:

- If the participant was pronounced dead after the ambulance was called but before pickup, a base rate will be allowed.
- If the participant was pronounced dead while in route to or upon arrival at the hospital, a base rate and mileage will be allowed.
- If the participant was pronounced dead by an authorized person before the ambulance was called, no payment will be made.

3.7.8 Ambulance Service Prior Authorization (PA)

3.7.8.1 Overview

All provider claims for ambulance services must be reviewed and authorized as medically necessary and appropriate by Medicaid Ambulance Review before Medicaid will reimburse the ambulance provider. Medicaid claims for ambulance services must include a PA number from Medicaid Ambulance Review, when submitted to EDS for payment.

3.7.8.2 Non-Emergency Ambulance Transportation

If non-emergency, scheduled travel by ambulance is medically necessary, PA is required before the transport occurs. PA is done by contacting Medicaid Ambulance Review prior to transport. For services that require PA, the PA number must be included on the claim or the claim will be denied.

Examples of non-emergent ambulance transport may be from a hospital to a rehabilitation center or nursing home, or a bed-ridden participant traveling from home to a scheduled medical appointment. A participant's life and health must be in jeopardy if transported by any means other than ambulance to a scheduled destination.

3.7.8.3 Emergency Transportation

Notify Medicaid Ambulance Review by fax or mail of all emergency transports by submitting a claim form, patient care record, and Explanation of Benefits from a third party payer, if applicable. See *Section 3.7.10 Requests for Retrospective Review/Authorization***,** for more information.

Contact Medicaid Ambulance Review at:

(208) 287-1157 in the Boise calling area
(800) 362-7648 (toll free)
Fax: (208) 334-5242 or **(800) 359-2236**

3.7.9 Ambulance Procedure Codes

All ambulance services by a non-hospital based ambulance should be billed on a CMS-1500 claim form or submitted electronically using the following HCPCS codes. It is not necessary to attach the run sheet to the claim. Payment for ambulance transport is for a one way trip in which the participant is in the patient compartment of the vehicle, except when a round trip is authorized by Medicaid Ambulance Review.

3.7.9.1 Ambulance Service Procedure Codes

Description	Code	Notes
Ground Ambulance		
Ambulance waiting time (ALS or BLS), 1/2 hour increments.	**A0420**	1 Unit = 1/2 Hour. Do not count the first 1/2, which is included in the base rate. Must be physician ordered.
Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged). Requires medical review.	**A0424**	Attendant must be in the patient compartment of the ambulance and actively treating or attending the patient. 1 Unit = Total charges for 1 extra attendant.
Ground mileage, per statute mile.	**A0425**	
Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1).	**A0426**	
Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency).	**A0427**	
Ambulance service, basic life support, non-emergency transport (BLS).	**A0428**	
Ambulance service, basic life support, emergency transport (BLS - emergency).	**A0429**	
Advanced life support, level 2 (ALS 2).	**A0433**	
Respond and evaluate, no other services (all levels).	**A0998**	Treat and release (ambulance response and treatment, no transport).
Response and treatment, basic life support.	**A0998**	
Response and treatment, advanced life support.	**A0998**	
Air Ambulance		
Ambulance service, conventional air services, transport, one way (fixed wing).	**A0430**	Base rate.
Ambulance service, conventional air services, transport, one way (rotary wing).	**A0431**	Base rate.
Fixed wing air mileage, per statute mile.	**A0435**	
Rotary wing air mileage, per statute mile.	**A0436**	

3.7.10 Requests for Retrospective Review/Authorization

To obtain a retrospective authorization for emergency services and transportation, fax or mail a copy of the completed claim form and patient care record to the Medicaid Ambulance Review. Attach a copy of the third party EOB if applicable.

Upon receipt of the completed claim information:

- The level of service requested by the provider is evaluated. The level of service billed cannot exceed the level of EMS certification unless the personnel providing care in the patient compartment have a higher level of certification than the ambulance license.
- The claim is evaluated for appropriate mileage. Disposable supplies are included in the base rate payment and may not be billed separately.
- Any potential denial or downgrade of the requested service is referred to an on-call emergency medicine physician for review prior to the denial or downgrade.

An approved or denied decision is submitted to EDS and a Notice of Decision for Medical Benefits is generated to the participant and the ambulance provider. The Notice of Decision will include a PA number

procedure codes, dates of service, and number of units necessary for billing. Questions regarding Notice of Decision for Medical Benefits should be directed to Medicaid Ambulance Review at:

(208) 287-1157 in the Boise calling area

(800) 362-7648 (toll free)

3.7.11 Requests for Reconsideration (Appeals)

Providers may appeal a PA decision made by DHW or its designee, by following these steps:

Step 1 Carefully examine the Notice of Decision for Medical Benefits to ensure that the service(s) and requested procedure code was actually denied. Occasionally a requested service/procedure code has been denied and the appropriate service/procedure code was actually approved on the next line in the notice. If the provider determines that an inappropriate denial of service has occurred, the next step is to submit a written Request for Reconsideration.

Step 2 Prepare a written Request for Reconsideration, which includes any additional extenuating circumstances and specific information that will assist the authorizing agent in the reconsideration review.

Step 3 Submit the written request directly to Medicaid Ambulance Review within 30 days of the date on the Notice of Decision for Medical Benefits. Medicaid Ambulance Review will return a second Notice of Decision for Medical Benefits to the requestor within 30 days of receipt of the provider's Request for Reconsideration. If the reconsidered decision is still contested by the provider, the provider may then submit a written request for an appeal of the reconsideration review decision directly to DHW.

A written appeal must be received within 28 days from the date on the Medicaid Ambulance Review reconsideration review decision, follow the steps below. Providers may fax all documentation but the fax must be followed with copies of original documents in the mail.

Step 1 Prepare a written request for an appeal that includes:

- Copy of the Notice of Decision for Medical Benefits from Medicaid Ambulance Review.
- Copy of the Request for Reconsideration from the provider.
- Copy of the second Notice of Decision for Medical Benefits from Medicaid Ambulance Review showing that the Request for Reconsideration was performed.
- Explanation of why the Request for Reconsideration remains contested by the provider.
- Copies of all supporting documentation.

Step 2 Mail the information to:

Hearings Coordinator
Idaho Department of Health and Welfare/Administrative Procedures Section
PO Box 83720
Boise, ID 83720-0036
Fax: (208) 332-7347

Contact Medicaid Ambulance Review with any questions about the Notice of Decision for Medical Benefits, the reconsideration decision, or the appeal process.

Contact Medicaid Ambulance Review at:

(208) 287-1157 in the Boise calling area

(800) 362-7648 (toll free)

Fax: (208) 334-5242 or **(800) 359-2236**

3.8 Claim Billing

3.8.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.8.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claims Submission*, *General Billing Information,* for more information.

3.8.2.1 Guidelines for Electronic Claims

Detail Lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral Number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a Healthy Connections (HC) participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior Authorization (PA) Numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the claim.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis Codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) Information with HCPCS and CPT Codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted.

Ambulance Services: Idaho requires the following information when submitting an electronic HIPAA 837 Professional transaction for ambulance services.

- Transport code.
- Transport reason code.
- Transport distance.
- Condition code.
- Round trip purpose when the transport code is equal to X for round trip.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for professional services.

3.8.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006.

3.8.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be returned that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).
- Only one PA number is allowed for paper claims.
- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim

3.8.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.8.3.3 Completing Specific Fields of CMS-1500

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

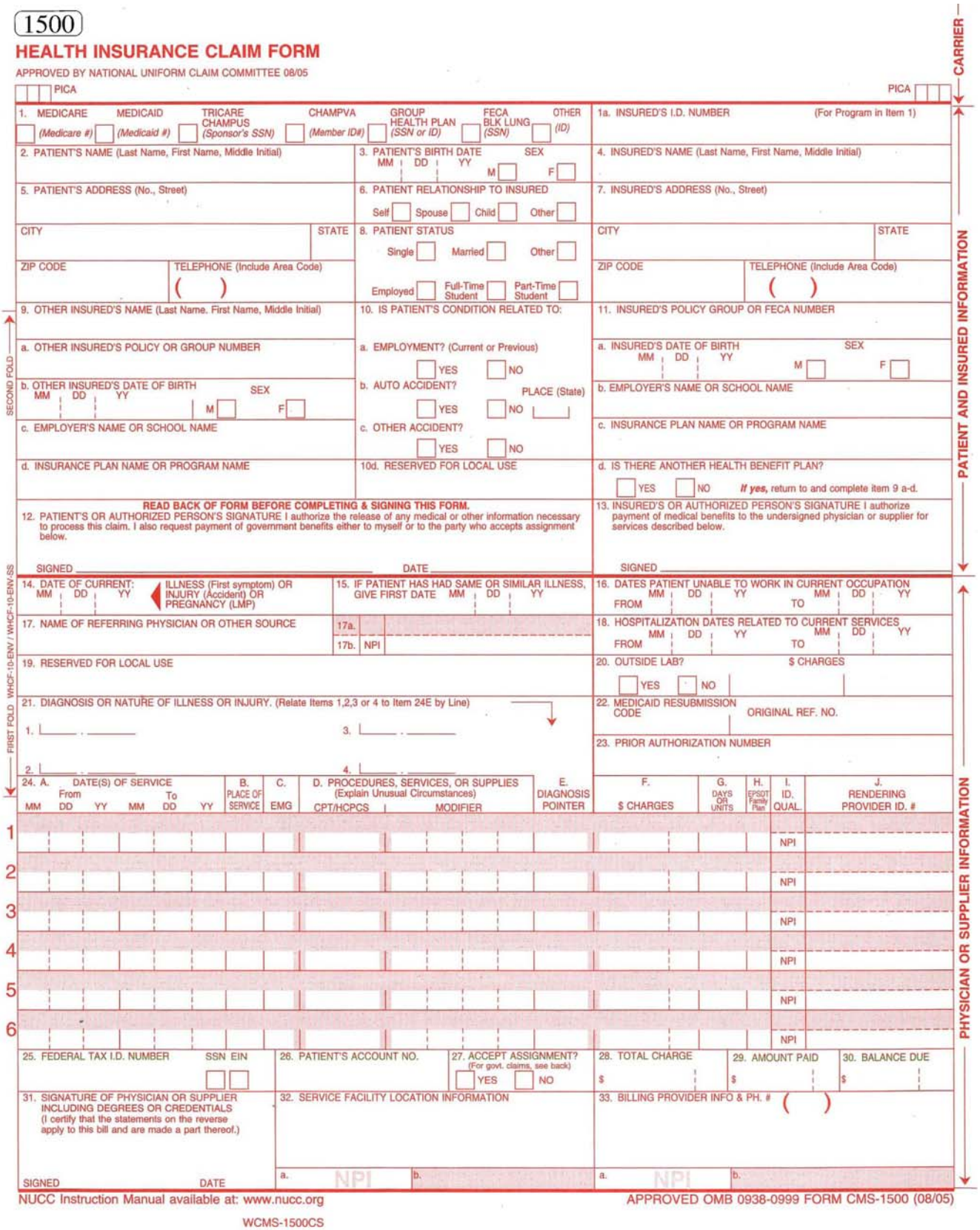
Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

Field	Field Name	Use	Directions
1a	Insured's ID Number	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name (Last Name, First Name, Middle Initial)	Required	Enter the participant's name exactly as it is spelled on the MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.
9a	Other Insured's Policy or Group Number	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required, if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Patient's Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Is Patient's Condition Related to Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Is Patient's Condition Related to Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a** - **9d**.
14	Date of Current Illness, Injury, or Pregnancy (LMP)	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness, Give First Date	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required, if applicable	Use this field when billing for a consultation or HC participant. Enter the referring physician's name.
17a	Blank Field	Required, if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For HC participants, enter the qualifier **1D** followed by the 9-digit HC referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI	Not required	Enter the referring provider's 10-digit National Provider Identifier (NPI) number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.

Field	Field Name	Use	Directions
19	Reserved for Local Use	Required, if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the internal control number (ICN) of previous claims to establish timely filing.
21 (1 - 4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, MT or Ambulance Review.
24A	Date(s) of Service, From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required, if applicable	If the services performed are related to an emergency, mark this field with an X.
24D 1	Procedures, Services, or Supplies CPT/HCPCS	Required	Enter the appropriate 5-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Procedures, Services, or Supplies Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Pointer	Required	Use the number of the subfield (1 - 4) for the diagnosis code entered in field **21**.
24F	$ Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT Family Plan	Required, if applicable	Not required unless applicable. If the services performed constitute an Early Periodic Screening Diagnosis and Treatment (EPSDT) Program Screen, see *Section 1.6 EPSDT*, for more information.
24I	ID Qual	Required, if Legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID #	Required, if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID # field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.

Field	Field Name	Use	Directions
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-on-File Form*, for more information.
33	Billing Provider Info & Ph #	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or Remittance Advice (RA). **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the provider master file can be updated.
33A	NPI	Desired, but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.
33B	Blank Field	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.8.3.4 Sample Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS